MARKET UPDATES

October, 2017

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Senate Draft Plan 6/22/17: Better Care Reconciliation Act

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- Key Updates to the proposed ACA replacement include:
  - Subsidies to help pay for insurance would end at incomes of 350 percent of poverty level, **with adults 59-64 paying up to 16.2 percent of income.** Medicaid would be cut starting in 2021.
  - Skilled nursing care covered by Medicare up to 100 days. **Medicaid coverage for long-term care could be cut** as federal payments to states decline.
  - Insurance companies would be required to accept all applicants regardless of health status, but the draft bill would **let states ask permission to reduce essential health benefits**
  - **Proposed cuts to Medicaid would be larger than those in the House bill (AHCA)**
  - **Federal funding for Medicaid expansion phases out between 2021 and 2023, with a "trigger clause" for AR, IL, IN, MI, MT, NH, NM, and WA**
  - **Similar to the House bill, the BCRA would repeal ACA taxes on corporations and the wealthy that pay for insurance subsidies**

Source: npr.org CHART: Who Wins, Who Loses With Senate Health Care Bill 6/22/17
http://www.npr.org/sections/health-shots/2017/06/22/533942041/who-wins-who-loses-with-senate-health-care-bill

BCRA versus the ACA

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How the Senate bill alters major parts of Obamacare

REPEAL	CHANGE	KEEP
Taxes created under Obamacare	Medicaid expansion	Pre-existing conditions policy
Subsidies for out-of-pocket costs	Tax credits for premiums	Dependent coverage until 26
Individual mandate	Essential health benefits	
Employer mandate	Prohibitions on annual and lifetime limits	
	Restrictions on charging more for older Americans	
	Health savings account	

Source: The New York Times 6/22/17 *Senate Health Care Bill Includes Deep Cuts to Medicaid*
https://www.nytimes.com/2017/06/22/us/politics/senate-health-care-bill.html

CBO Report on BCRA (7/19/17)

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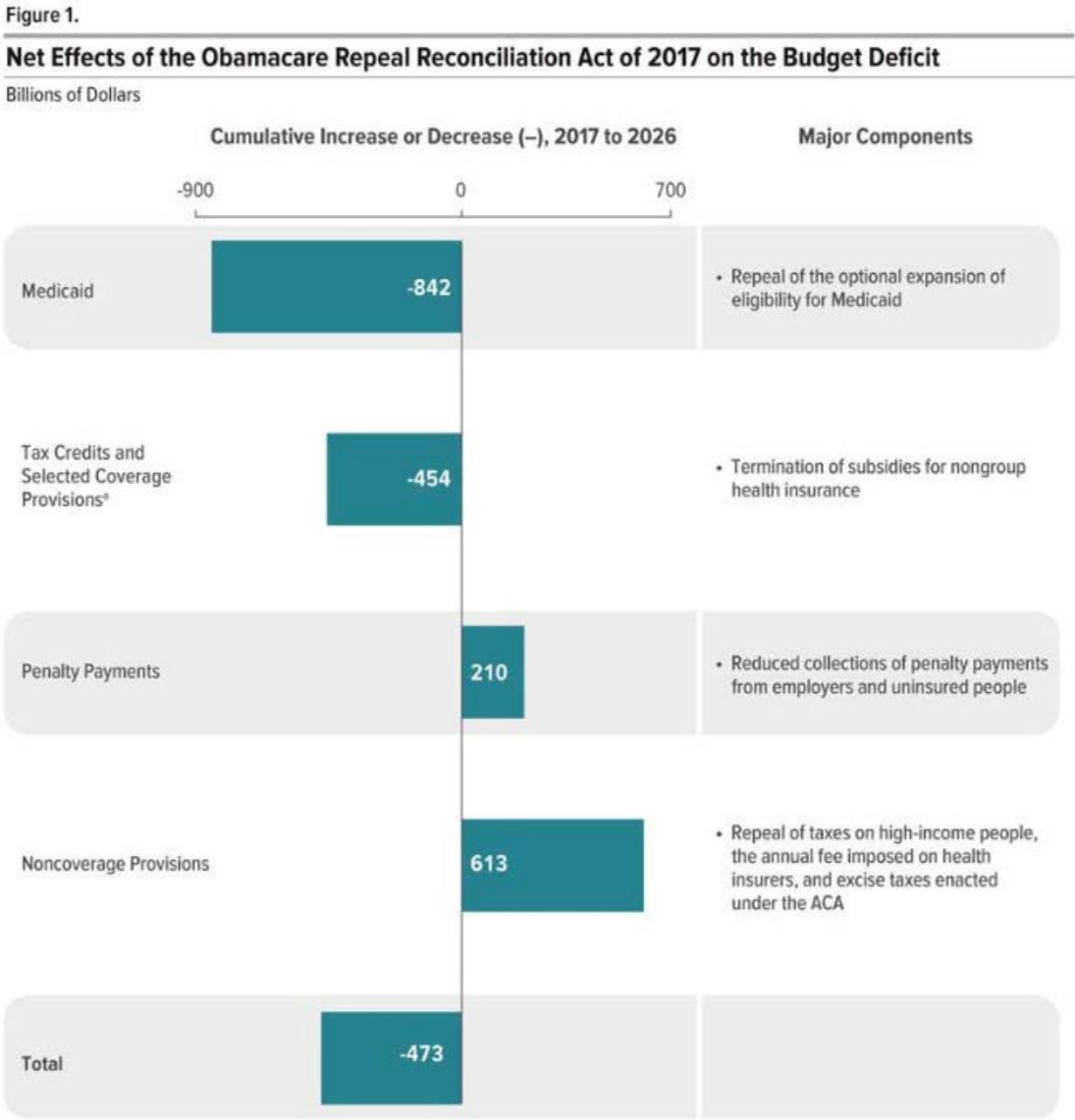
CONGRESSIONAL BUDGET OFFICE
COST ESTIMATE

July 19, 2017

H.R. 1628
Obamacare Repeal Reconciliation Act of 2017

An Amendment in the Nature of a Substitute [LYN17479]
as Posted on the Website of the Senate Committee on the Budget on July 19, 2017

- Uninsured would increase to 17M in 2018, increasing to 27M in 2020 after elimination of the ACA's expansion of Medicaid eligibility and elimination of subsidies for insurances purchased through the marketplaces, and then to 32M in 2026
- Average premiums in the non-group market (for individual policies purchased through the marketplaces or directly from insurers) would increase by 25% in 2018.
  - Increase would reach 50% in 2020, and double by 2026



BCRA Fails on First Pass (7/24/17)

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Opinion & Editorial Research & Data Center

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First Senate ACA repeal vote fails as debate begins

By Mara Lee | July 25, 2017

(Updated at 10:40 p.m. ET)

Senate Republicans' first vote to repeal and replace Obamacare came nowhere close to passing Tuesday night after hours of debate on their yearslong pledge to tear down the healthcare law.

RELATED CONTENT

Third time was not the charm for McConnell's vow

BCRA: Rejected 57-43 (7/25/17)

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- On 7/25/2017, the Senate again failed to pass a revised version of the BCRA
- The proposal included the **"Cruz amendment",** which would allow insurers to sell plans that do not comply with some current insurance regulations, as long as they also offer a set of plans that do
  - **Insurers would have been able to deny coverage to customers with pre-existing conditions**
- The bill would have **kept in place two taxes on high-income earners that were eliminated in earlier versions, and add new state stability funding, to be devoted to cost-sharing reduction**

Source: The New York Times, *The Three Plan to Repeal Obamacare That Failed in the Senate This Week, https://www.nytimes.com/interactive/2017/07/25/us/which-health-bill-will-the-senate-vote-on.html*

Obamacare Repeal and Reconciliation Act: Rejected 55 to 45 (7/26/17)

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- On 7/26/17, the Senate rejected a bill that would have repealed majors parts of the ACA without a replacement
- This version would have **repealed the coverage provisions in the Affordable Care Act, including the individual mandate, Medicaid expansion and premium subsidies in two years,** but left in place insurance market reforms like ensuring a base level of coverage
- **The Congressional Budget Office estimates that 32 million more people would be without health insurance than under the current law, the most of any of the Republican proposals**

Sources: Health Affairs blog 7/19/17 by Timothy Jost http://healthaffairs.org/blog/2017/07/19/the-obamacare-repeal-reconciliation-act-what-repeal-and-delay-would-mean-for-coverage-premiums-and-the-budget/; The New York Times, *Health Care Vote: Senate Rejects Repeal Without Replace,* Thomas Kaplan and Eileen Sullivan https://www.nytimes.com/2017/07/26/us/politics/health-care-senate-vote.html; The New York Times, *The Three Plan to Repeal Obamacare That Failed in the Senate This Week, https://www.nytimes.com/interactive/2017/07/25/us/which-health-bill-will-the-senate-vote-on.html*

"Skinny Repeal": Rejected 51 to 49 (7/28/17)

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- On 7/28, the Senate voted 49-51 to reject a scaled-back repeal of parts of the Affordable Care Act (ACA). "No" votes came from Senators Collins (R-ME), Murkowski (R-AK) and McCain (R-AZ).
- The details of the legislation to repeal and replace parts of the ACA remained unclear until shortly before legislators moved to pass the measure
- According to published reports, the skinny bill included:
  - repealing individual and temporarily repeal employer mandates;
  - repealing the medical device tax;
  - ending federal funding for one year of Planned Parenthood;
  - eliminating the Prevention and Public Health Fund; and
  - authorizing an expedited 1332 waiver process, which could allow states to cut essential health benefits and other ACA provisions.
- **There is no indication that the bill would affect Medicaid**

Source: hfma.org, *Senate Rejects 'Skinny' GOP Health Reform Bill,* Rich Daly, 7/28/17

House Problem Solvers Caucus – 7-30-2017

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- Bipartisan group of 21 Republicans and 22 Democrats
  - Agreed on principles for improving Obamacare
  - Agreement that once members reach consensus to issues, they pledge to vote as a bloc
- Key provisions
  - Securing $7B in appropriations for cost-sharing reduction (CSR) payments to insurance companies for offering low-income customers (below 250% of poverty level) reduced co-pay and deductibles
  - Create a stability fund that states could use to reduce premiums and limit insurer losses, especially for people with pre-existing conditions
  - Employer mandate apply only to companies with 500 or more employees
  - Revise guidelines on Medicaid 1332 waivers (used by MN and AK to establish reinsurance programs) and provide clear guidance on Section 1333 (selling insurance across state lines)
  - Repeal the medical-device tax

CBO Report on Terminating CSR Payments (8/15/17)

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Congressional Budget Office

AUGUST 2017

The Effects of Terminating Payments for Cost-Sharing Reductions

- Most people would pay net premiums (after premium tax credits) of the same amount through the next decade
- Federal deficits would increase by $6B in 2018, $21B in 2020, and $26B in 2026
- Number of uninsured would be slightly higher in 2018 and slightly lower starting in 2020

FY 2018 IPPS Proposed Rule 4-14-2017/Finalized 8-3-2017

STROUDWATER

On April 14, 2017, CMS released its IPPS Proposed Rule for 2018. Important proposals include:

- **CAH 96-hour certification requirement now a "Low Priority"**
  - Beginning October 1, 2017, CAHs will not receive any medical record requests from Medicare contractors related to 96-hour certification unless gaming suspected
- **Medicare Inpatient payment rate to increase 1.6%**
  - Market basket increase of 2.9% reduced by .4% productivity cut and .75 ACA reduction

Factor	Percent Change
FY 2018 inflation (market basket) update	2.9
Multifactor productivity adjustment	-0.4
Additional -0.75 percentage point update adjustment required by the ACA	-0.75
Subtotal – "applicable percentage increase"	*1.75*
Documentation and Coding Adjustment Required by 21st Century Cures Act	+0.4588
"2 Midnight" Adjustment	-0.6
Net increase in national standardized amounts (before application of budget neutrality factors)	*1.6088**
*CMS displays this amount as 1.6 percent on page 1692 of the display copy of the final rule. In column 1 of the impact table on page 1687, this figure is 1.5 percent to reflect the lower update for hospitals that are paid in full or part based on hospital-specific rates.	

FY 2018 IPPS Proposed Rule 4-14-2017/Finalized 8/3/17) (continued)

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Table I Impact Analysis

Detailed impact estimates are displayed in Table I of the proposed rule (reproduced in the Appendix to this summary). The following table summarizes the impact by hospital category.

Hospital Type	All Proposed Rule Changes
All Hospitals	1.7%
Large Urban	1.7%
Other Urban	1.8%
Rural	0.8%
Major Teaching	1.6%

Socioeconomic adjustment to by implemented by 2019 for Hospital Readmissions Reduction Program

- Leveling of playing field for hospitals serving low income/disadvantaged patients
- **Worksheet S-10 to be used as basis for determining Uncompensated Care costs and reimbursement**
  - To be implemented over a three year period
  - Definition of uncompensated care costs to include all unreimbursed (Medicaid Shortfalls and discounts for uninsured) and uncompensated care costs
- **Proposed Rule Finalized on August 3, 2017**

340B Program Under Continued Attack 6-01-2017

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GREG WALDEN, OREGON
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FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FIFTEENTH CONGRESS

Congress of the United States

House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115
Majority (202) 225–2927
Minority (202) 225–3641

June 1, 2017

Mr. George Sigounas
Administrator
Heath Resources and Services Administration
U.S. Department of Health and Human Services
5600 Fishers Lane
Rockville, MD 20857

Dear Administrator Sigounas:

The Committee is concerned about the 340B program's rapid growth without additional and proportional oversight. Provisions in the Patient Protection and Affordable Care Act (PPACA) expanded the definition of eligible entities to include "free-standing cancer, community and critical access hospitals on the basis of their disproportionate share hospital (DSH) percentage,"[3] which has increased program enrollment substantially.[4] 340B drug sales

340B Program Under Continued Attack 6-01-2017

STROUDWATER

To assist with the Committee's oversight of the 340B program, please provide all documents collected by HRSA referring or relating to covered entity audits conducted during FY 2015 and FY 2016, including but not limited to items #1, #2, and #3 in the Covered Entity Data Request document provided to the Committee by June 15, 2017.

Thank you for your prompt attention to this matter. An attachment to this letter provides additional information about how to respond to the committee's request. If you have any questions regarding this request, please contact Brighton Haslett or Jennifer Barblan with the majority committee staff at (202) 225-2927.

Sincerely,

Greg Walden
Chairman
Committee on Energy and Commerce

Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

Michael C. Burgess, M.D.
Chairman
Subcommittee on Health

340B Program Under Continued Attack (8-21-2017)

STROUDWATER

- Delayed implementation of 340B Program ceiling price and manufacturer civil monetary penalties from October 1, 2017, to July 1, 2018

This document is scheduled to be published in the Federal Register on 08/21/2017 and available online at https://federalregister.gov/d/2017-17633, and on FDsys.gov

BILLING CODE 4165-15

DEPARTMENT OF HEALTH AND HUMAN SERVICES

42 CFR Part 10

RIN 0906-AB11

340B Drug Pricing Program Ceiling Price and Manufacturer Civil Monetary Penalties Regulation

AGENCY: Health Resources and Services Administration, HHS.

ACTION: Notice of proposed rulemaking; further delay of effective date.

FY 2018 OPPS Proposed Rule 7-20-2017

STROUDWATER

On July 20, 2017, CMS released its OPPS Proposed Rule for 2018. Important proposals include:

- **Medicare OPPS conversion factor to increase 1.9%**
  - 2.9% Inflation less .4% productivity and .75% ACA Adjustment

	Projected 2018 Impact
All Facilities*	1.9%
All Hospitals	2.0%
Urban Hospitals	2.0%
Rural Hospitals	2.0%
Major Teaching	1.7%
Minor Teaching	2.0%
Non-Teaching	2.1%
Ownership	
Voluntary	1.9%
Proprietary	2.3%
Government	1.9%

*Excludes hospitals permanently held harmless and CMHCs

FY 2018 OPPS Proposed Rule 7-20-2017 (continued)

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Payment for Part B Drugs Acquired Under the 340B Program

- Beginning in FY 2018, CMS to reduce payment for Part B drugs acquired under the 340B program from average sales price (ASP) +6% to ASP -22%
- "We believe that any payment changes should be limited to separately payable drugs under the OPPS, with certain exclusions" (Page 305)

Non Exempt Provider Based Clinics (under section 603 of Bipartisan Budget Act of 2015)

- Proposing to reduce payment for non-exempt provider-based clinics (new off-campus clinics that were not in process by 11/2/2015) from 50% of OPPS payment to 25%

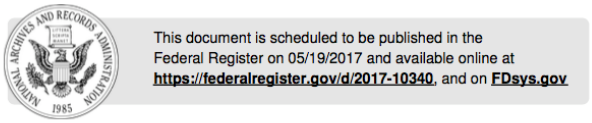
Direct Supervision of Hospital OP Therapeutic Services

- Reinstate non-enforcement of direct supervision requirements for OP therapeutic services for CAHs and small rural hospitals for CYs 2018 and 2019

Delay of Bundled Payment Final Rule 6-02-2017

STROUDWATER

- Delayed implementation of bundled payment rules from July 1, 2017, to January 1, 2018



CMS-5519-F3

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 510 and 512

[CMS-5519-F3]

RIN 0938-AS90

Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs); Cardiac Rehabilitation Incentive Payment Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR); Delay of Effective Date

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; delay of effective date.

MedPAC Report to Congress 5/18/2017

STROUDWATER

MEDPAC Medicare Payment Advisory Commission

TESTIMONY

"Congress and CMS need to correct the considerable overpayments in the existing Post Acute Care (PAC) payment systems"

- **Skilled Nursing Facilities (SNF)**
  - No updates to SNF payment for 2 years while SNF PPS is revised. In 2020, make further adjustments to bring payments into better alignment with costs
- **Home Health Care**
  - To be implemented over a three year period
  - Revise the payment system to base payments on patient characteristics and eliminate the use of units of therapy as payment factor
- **Inpatient Rehab Facilities**
  - Fiscal 2018 payments to be reduced by 5% coupled with expansion of high-cost outlier pool
- **Long-term Care Hospital Services**
  - No updates to payment for 2018

FY 2018 HHA Proposed Rule 7-25-2017

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TABLE 1: Summary of Costs and Transfers

Provision Description	Costs	Transfers
CY 2018 HH PPS Payment Rate Update		The overall economic impact of the HH PPS payment rate update is an estimated -$80 million (-0.4 percent) in payments to HHAs.
CY 2018 HHVBP Model		The overall economic impact of the HHVBP Model provision for CY 2018 through 2022 is an estimated $378 million in total savings from a reduction in unnecessary hospitalizations and SNF usage as a result of greater quality improvements in the HH industry (none of which is attributable to the changes proposed in this proposed rule). As for payments to HHAs, there are no aggregate increases or decreases expected to be applied to the HHAs competing in the model.
CY 2019 HH QRP	The overall economic impact of the HH QRP changes is a savings to HHAs of an estimated $44.9 million, beginning January 1, 2019.	
CY 2019 HH PPS Case-Mix Adjustment Methodology Refinements		The overall impact of the proposed HH PPS case-mix adjustment methodology refinements, including a change in the unit of payment from 60-day episodes to 30-day periods of care, is an estimated -$950 million (-4.3 percent) in payments to HHAs in CY 2019 if the refinements are implemented in a non-budget neutral manner for 30-day periods of care beginning on or after January 1, 2019. The overall impact is an estimated -$480 million (-2.2 percent) in payments to HHAs in CY 2019 if the refinements are implemented in a partially budget-neutral manner.

State DSH Allotment Reductions – Proposed Rule 7-28-2017

This document is scheduled to be published in the Federal Register on 07/28/2017 and available online at https://federalregister.gov/d/2017-15962, and on FDsys.gov

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Part 447

[CMS-2394-P]

RIN 0938-AS63

Medicaid Program; State Disproportionate Share Hospital Allotment Reductions

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Proposed rule.

- Proposed rule delineates the DSH Health Reform Methodology (DHRM) to implement annual Medicaid allotment reductions required as part of ACA
  - Reductions to occur between FY2018 and FY2025
  - Note: TN excluded from reductions

State DSH Allotment Reductions – Proposed Rule 7-28-2017

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- Methodology must:
  - Impose a smaller % reduction on low DSH states
  - Impose largest % reductions on:
    - States that have lowest % of uninsured individuals
    - States that do not target DSH payments on hospitals with high volume of Medicaid patients
    - States that do not target their DSH payments on hospitals with high levels of uncompensated care
- Reductions to occur as follows:
  - $2B for FY 2018
  - $3B for FY 2019
  - $4B for FY 2020
  - $5B for FY 2021
  - $6B for FY 2022
  - $7B for FY 2023
  - $8B for FY 2024
  - $8B for FY 2025

10/2/17: House Proposes Delay in Cuts to DSH Funding

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- A House committee moved to delay a multibillion-dollar cut to Medicaid DSH funds that was required by the Affordable Care Act
  - The ACA's cuts start at $2B in 2018 and end at $8B in 2025
- The committee proposed eliminating the 2018 cuts and offsetting the loss by extending DSH reductions through 2027
- Hospitals would face a $16B cut over the two proposed additional years
- **While hospitals are pleased by the proposed delay, it does not solve the larger problem of uncompensated care faced by essential hospitals and their communities**

Source: Modern Healthcare, *House Panel proposes delay in cuts to uncompensated-care funding,* October 3, 2017
http://www.modernhealthcare.com/article/20171003/NEWS/171009984

Medicare ACOs Cut $1B Over Three Years

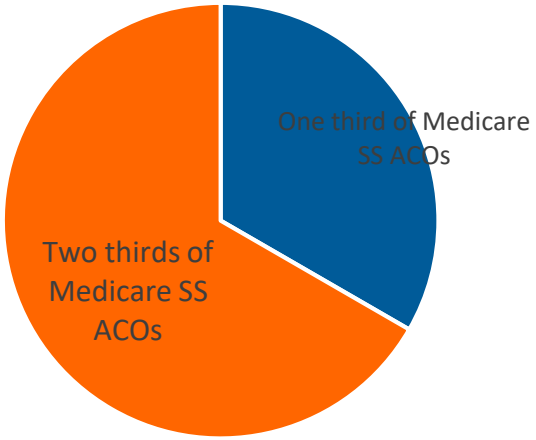
STROUDWATER

Accountable care organizations participating in the CMS' Medicare shared-savings program reduced spending by about $1 billion in three years per the HHS OIG

"While policy changes may be warranted, ACOs show promise in reducing spending and improving quality," the OIG report concluded.

Most of the 428 ACOs in the first three years of the shared-savings program reduced Medicare spending compared to their benchmarks, and a small group of those ACOs produced "substantial" savings

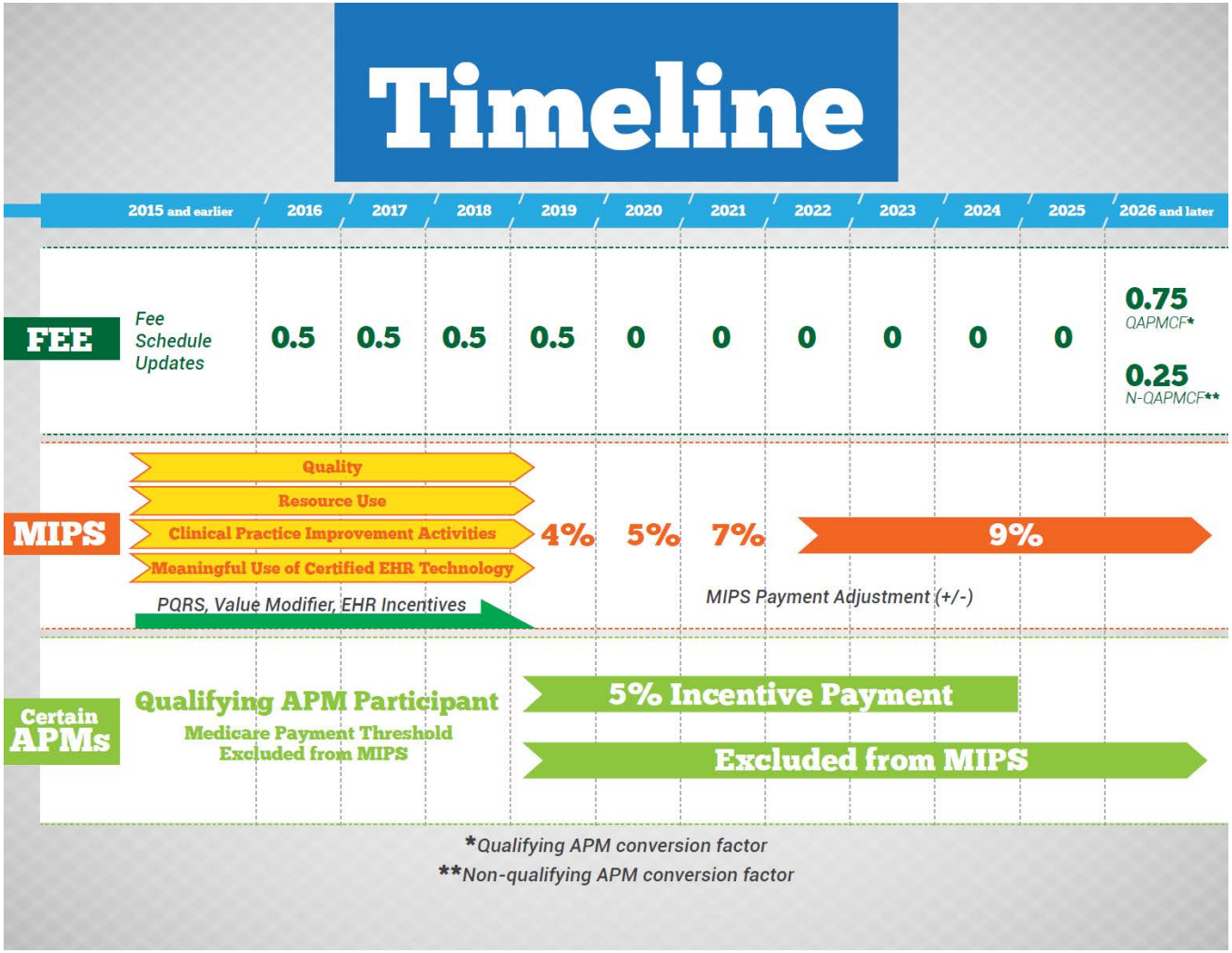
82% of the ACOs also improved the quality of care they provided, based on data from the CMS on 33 individual quality measures, outperforming fee-for-service providers in 81% of the quality measures



- Reduced spending enough to receive a portion of the savings during the first three years of the program
- Reduced spending for at least one of the years they participated in the program.

Source: **Medicare shared-savings ACOs cut $1 billion in costs over three years, Shelby Livingston** | August 29, 2017, modernhealthcare.com
OIG Report: https://oig.hhs.gov/oei/reports/oei-02-15-00450.asp

MACRA



Source: https://qpp.cms.gov/

CMS Proposes to Exempt Smaller Practices from MACRA

STROUDWATER

A new draft rule released 6/20 would exempt physician practices with **less than $90,000 in Medicare revenue or fewer than 200 unique Medicare patients per year** from MACRA

Combined, this exemption and the proposed one for next year **will exclude around 834,000 more clinicians** from complying with the program

The CMS in fact reports that **65% of Medicare payments would still be reported under MACRA's quality reporting program** even if this draft rule were finalized

Source: *CMS gives more small practices a pass on MACRA*, Virgil Dickson, modernhealthcare.com 6/20/17

10/5/17: MedPAC Urges Repealing MIPS

STROUDWATER

The Medicare Payment Advisory Commission (MedPAC) is pushing for the immediate repeal and replacement MIPS, a Medicare payment system and component of MACRA that aims to improve quality of care

MedPAC believes that MIPS is severely flawed, for reasons including

- MIPS measures provider performance instead of patient outcomes
- MIPS allows providers to choose the measures under which they will be evaluated
- Some MIPS categories rely on physician self-reporting
- CMS estimates that providers will spend over $1 billion to report and track MIPS measures in 2017

MedPAC's proposed alternative includes

Eliminating MIPS and withholding 2% of payments to physicians not in an APM

- To get the money back, doctors not in an APM could be a part of a new voluntary pay model in which they join a group of clinicians and are evaluated on performance-based measures
- Doctors could also choose to remain in fee-for-service and lose out on the 2% of reimbursement that was withheld

Source: Modern Healthcare, *MedPAC urges repealing MIPS,* Virgil Dickson, 10/5/17
http://www.modernhealthcare.com/article/20171005/NEWS/171009958

10/6/17: More from MedPAC

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One day after it urged a repeal of MIPS, MedPAC called for eliminating two major quality improvement programs

- Inpatient Quality Reporting Program
- Hospital Acquired Condition Reduction Program

MedPAC will also ask Congress to combine the Hospital Readmissions Reduction Program and the Hospital Value-Based Purchasing Program into one new program called the Hospital Value Incentive Program

- This new program would score hospitals on readmissions, mortality, spending rates, and patient experience
- Much like the proposed replacement for MIPS, this new program would withhold 2% of Medicare reimbursements

"There are currently too many overlapping programs, which creates unneeded complexity for Medicare and for hospitals. For simplicity, hospitals should have their payment adjusted under one program as opposed to separate programs."

-Ledia Tabor, MedPAC policy analyst

Source: Modern Healthcare, *MedPAC seeks to junk two hospital quality programs, merge others,* Virgil Dickson, 10/6/17 http://www.modernhealthcare.com/article/20171006/NEWS/171009937

No-Pay for Non-Emergent ED Use

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HEALTHCARE BUSINESS NEWS

No-Pay Policy for Non-Emergent ED Use Spreading

RICH DALY, HFMA SENIOR WRITER/EDITOR

164 26

THE POLICY IS EXPECTED TO INCREASE THE BAD-DEBT FINANCIAL BURDEN ON HOSPITALS AND AFFILIATED PHYSICIANS, A HOSPITAL ADVOCATE SAYS.

June 7—By mid-summer, Anthem Blue Cross and Blue Shield (BCBS) plans in at least four states are expected to offer no payment for non-emergent use of the emergency department (ED).

BCBS Georgia individual-market plans on July 1 will become the newest group to implement the policy. Anthem added the policy for its Missouri plans on June 1 and for its Kentucky plans in late 2015. Meanwhile, New York plans have had a "similar program in place for several years," said Gene Rodriguez, director of public relations for Anthem Inc.

Anthem Blue Cross/Blue Shield Diagnostic Imaging

STROUDWATER

- ***CT / MRI Coverage Denials @ Hospital Site of Service***

Anthem BlueCross BlueShield

Imaging program expands to include level of care reviews
FAQs

Background: *Effective with dates of service on or after July 1, 2017, for members covered by local plans in Indiana, Kentucky, Missouri and Wisconsin, and on or after September 1, 2017, for members covered by the local plan in Ohio, Anthem Blue Cross and Blue Shield (Anthem) requires a medical necessity review of the requested level of care for computed tomography (CT) imaging and magnetic resonance imaging (MRI). A new clinical guideline, Level of Care: Advanced Radiologic Imaging, CG-MED-55, applies to the review process. The review is administered by AIM Specialty Health® (AIM), a separate company.*

Q: What services are included in the expanded imaging program?
A: Effective July 1, 2017, for IN, KY, MO and WI, and effective September 1, 2017 for OH, AIM Specialty Health® (AIM) will review requested level of care for advanced imaging services, i.e., computed tomography (CT) imaging and magnetic resonance imaging (MRI). AIM will review the precertification request and the level of care against health plan clinical criteria.

Q. When will AIM approve CT scans or MRIs in a hospital setting?
A. If it is medically necessary that the CT scan or MRI be provided in a hospital setting, then members will receive approval to receive the service in a hospital setting. If it is NOT medically necessary for the member to receive the service in a hospital setting, the request for authorization will be denied as not medically necessary for that site of care. Existing authorizations will be honored until the authorization expires.

IRS Revokes Tax-Exempt Status (8-17-2017)

STROUDWATER

IRS revokes hospital's tax-exempt status for failure to comply with ACA rule

Written by Ayla Ellison (Twitter | Google+) | August 17, 2017 | Print | Email

The Internal Revenue Service has revoked the tax-exempt status of an unnamed nonprofit hospital for failure conduct a community health needs assessment, adopt an implementation strategy and make it widely available to the public.

In a letter dated Feb. 14, 2017, and released earlier this month, the IRS said it revoked the hospital's tax-exempt status for failure to comply with section 501(r) of the Internal Revenue Code.

The ACA added new requirements that hospitals must meet to qualify as a tax-exempt facility under section 501(c)(3) of the Internal Revenue Code. Specifically, the ACA added section 501(r), which imposes four new requirements, one of which requires hospitals to conduct a community health needs assessment at least once every three years and adopt an implementation strategy to address community health needs identified in the assessment.

The IRS revoked the tax-exempt status of the unnamed hospital for what the agency referred to as "egregious failures when reviewed in the context of [section] 501(r)." Although the name of the hospital is not included in the letter from the IRS, previous correspondence from the agency identified the facility as a disproportionate share hospital and a critical care access facility.

Source: *Becker's Hospital Review 8-17-2017*

10/4/17: CHIP Proposals Pass House and Senate

STROUDWATER

On October 4, the House and Senate each passed bills that would reauthorize CHIP, the federal program that provides affordable health insurance to **8.9m children and 370k pregnant women**

- The Senate quickly passed its bill, the Keeping Kids' Insurance Dependable and Secure (KIDS) Act, which extends CHIP for five years
- The House bill, which proposed offsetting the cost of CHIP by charging higher Medicare premiums to seniors earning over $500k

Congress last funded CHIP through the Medicare Access and CHIP Reauthorization Act of 2015, which provided nearly $40B in federal funding to states and ended Sept. 30

Without CHIP reauthorization, providers are worried millions of children will lose access to healthcare

Source: Modern Healthcare, *House, Senate committees pass CHIP bill proposals,* Virgil Dickson, 10/4/17
http://www.modernhealthcare.com/article/20171004/NEWS/171009974

CMS Seeks New Direction for Payment Models

STROUDWATER

In mid-September, CMS released a Request for Information **"seeking your feedback on a new direction to promote patient-centered care and test market-driven reforms that empower beneficiaries as consumers, provide price transparency, increase choices and competition to drive quality, reduce costs, and improve outcomes"**

This request indicates a potential interest in changing the alternative payment models the Obama Administration had employed to reduce Medicare costs and improve quality and patient safety

The Innovation Center is interested in testing models "that include increasing participation in advanced alternative payment models (APMs) and models focused on consumer-directed care and market-based innovation; physician specialty care; prescription drugs; Medicare Advantage innovation; and state-based and local innovation, including Medicaid-focused models mental and behavioral health and improving program integrity."

Sources: HFMA Healthcare Business News, *CMS Seeks New Payment Model Direction,* Mark Taylor, 9/26/17
and CMS Innovation Center *https://innovation.cms.gov/Files/x/newdirection-rfi.pdf*

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